Enrollment Application

1. Participant Information

Last Name _____   First _____   Initial _____

Social Security Number _____   ☐ Female   ☐ Male   Date of Hire/Rehire _____

Address _____   City _____   State ____   Zip _____

Phone _____   Date of Birth _____

Employer _____   Division/Location/Local _____

Occupation _____   Salary _____

2. Insurance Information

Are you or any of your dependents covered by any other medical or dental coverage? ☐ Yes   ☐ No

If yes, please put a check next to those who have such coverage: ☐ Yourself   ☐ Your Spouse   ☐ Children

Name of Carrier _____

Policy # _____   Type of Coverage _____

Is member or dependent Medicare eligible? ☐ Yes ☐ No If yes, effective dates: Part A _____   Part B _____

Medicare Eligible Last Name_____   First _____   Initial _____

3. Insurance Beneficiary

Name _____   Relationship to you _____

4. Dependents

Are you under court order to provide health coverage?   ☐ Yes   ☐ No

If you answered yes, please attach the Qualified Medical Child Support Order (QMCSO) to this form.

Below, please list all dependents to be covered:

	Last Name	First Name	Middle Initial	Check One F=Female M=Male	Rel. to Employee	Date of Birth	Social Security Number
Spouse				☐ F ☐ M			
Child				☐ F ☐ M			
Child				☐ F ☐ M			
Child				☐ F ☐ M			
Child				☐ F ☐ M			

5. Waiver

☐   I am not electing coverage at this time.

I have completed this application and believe it to be true and accurate to the best of my knowledge. I understand that the failure to disclose true and accurate information may result in the immediate termination of the benefits. I understand that the benefits will not be in effect until I have satisfied the eligibility requirements for coverage under the Plan. I herby authorize any physician, medical practitioner, hospital, clinic, veterans administration facility, other medical related facility, insurance or reinsurance company or consumer reporting agency having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me or my named dependents, to give to the Plan, its legal representative, management care firm, pre-certification or utilization review firm, any and all such information.

Signature _____   **Date** _____

-- *For Plan Manager Use Only* --

Effective Date _____   Class _____   Division Code _____   Client Code _____